Medicaid Pharmacy Request Form
Synagis® Prior Authorization

FAX: (800) 748-0116
Phone: (800) 748-0130

Fax or Mail to
HEALTH INFORMATION DESIGNS

P.O. Box 3210
Auburn, AL 36832-3210

PATIENT INFORMATION

Patient Name _____ Patient Medicaid # _____

Patient DOB _____ Patient phone # with area code _____

PRESCRIBER INFORMATION

Prescribing physician _____ License # _____

Phone # with area code _____ Fax # with area code _____

Address (Optional) _____
(Address/City/State/Zip)

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Supporting documentation is available in the patient record.

_____
Physician's signature Date

DRUG/CLINICAL INFORMATION

Drug requested _____ Strength _____

J Code _____ Qty. per month _____ NDC # _____
(if applicable)

Diagnosis or ICD-9 Code* _____ Diagnosis or ICD-9 Code* _____

Current weight _____ kg. Number of doses requested _____

(Check applicable age, condition and risk factors)

- ❒ Gestational age ≤ 28 wks & infant is < 12 months
- ❒ Gestational age 29-32 wks & infant is < 6 months
- ❒ Gestational age 33-35 wks & infant < 6 months with AAP risk factors*
  AND
- ❒ Currently outpatient with no inpatient stay in the last 2 weeks.
- ❒ Child is < 24 months old with Chronic Lung Disease*
- ❒ Child is < 24 months old with Congenital Heart Disease*

*Document AAP risk factor(s) and/or other required medical justification .

Medical justification _____

❒ **Additional medical justification attached.**

❒ A dose of Synagis® was administered while patient was hospitalized. Date dose administered _____

PHARMACY INFORMATION

Dispensing pharmacy _____ Provider # _____

Phone # with area code _____ Fax # with area code _____

FOR HID USE ONLY

❒ Approve request ❒ Deny request ❒ Modify request ❒ Medicaid eligibility verified

Comments _____

_____ _____
Reviewer's Signature Response Date/Hour